STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: April 9, 10, 11, and 12, 2012 Facility number: 012523 Provider number: 155789 AIM number: 201027870 Survey team: Janie Faulkner, RN TC Diana Sidell, RN Jill Ross, RN Cheryl Fielden, RN Susan Worsham, RN Census bed type: SNF 33 SNF/NF 11 Residential 29 Total 73 Census payor type: Medicare 26 Medicaid 9 Other 38 Total 73 Sample: 11 Supplemental sample: 1	F0000	The submission of this Plan of Correction does not indicate an admission by RidgeWood Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of RidgeWood Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Residential sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on April 19, 2012 by Bev Faulkner, R.N.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to ensure care plans were reviewed and revised after a resident received new orders to apply a wound vac. This affected 1 of 11 residents reviewed for care plan review/revision in a sample of 11. (Resident #30) Findings included: The record of Resident #30 was reviewed on 4/11/12 at 10:00 a.m. The record indicated Resident #30 had diagnoses that included, but were not limited to, insulin dependent diabetes, post surgical left	F0280	**1. Resident # 30 has been discharged from the facility.** **2. Other residents with new MD orders for the month of April were reviewed by DHS/ADHS or unit manager to assure care plans were updated and any discrepencies noted were corrected.** **3 Nurses were in-serviced by DHS/ADHS on updating care plans with MD orders** **4. Audits will be conducted**	05/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	below the knee amputation (BKA),cellulitis of the left below the knee area, diabetic neuropathy, osteomyelitis, and depression. An emergency room "visit summary report", dated 3/10/12, at 9:17 p.m., indicated the resident fell onto her left stump in the shower earlier that evening. Resident #30 was transported to ER where physician's records indicated the resident displaced 5 staples from the surgical wound site. An order for wet to dry dressings to the area was ordered, and Resident #30 was returned to facility. A care plan, dated 3/30/12, did not include any plan of care for the left BKA wound. The care plan had "wound vac" written at the end of the care plan, with no information related to the site, type of wound, when it was to be changed, or assessing/measuring the wound. During an interview with the Director of Health Services (DHS) and the Clinical Wound Care Nurse (CWCN) on 4/11/12 at 2:10 p.m., they indicated that on 3/17/12, an order was received to place a wound vac on Resident #30's left stump area post surgical BKA. A physician's order, dated 3/17/12, indicated to apply a wound vac to		**by DHS/ADHS or unit manager regarding care plan revision of MD orders. 10 MD orders will be reviewed 5 times per week in CQI for 4 weeks, then 5 orders 3 times per week in CQI for 8 weeks. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #30's left stump due to the non healing of the wound with prescribed wet to dry dressings. A physician's telephone order, dated 3/20/12, indicated an order to change the wound dressing for the wound vac every 3 days. A policy and procedure for "Facilities [sic] Interdisciplinary Team Careplan," dated 01/06, was provided by the CWCN on 4/12/12 at 2:20 p.m., included, but was not limited to: "...update the Initial Admission Careplan, based on further assessments as needed...." There was no indication the facility reviewed and revised the care plan when the new physician's order for the wound vac was given. 3.1-35(d)(2)(B)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure thorough and consistent assessment of a wound requiring the use of a wound vac for 1 of 11 residents reviewed for assessment and care in a sample of 11. (Resident #30) Findings include: The record of Resident #30 was reviewed on 4/11/12 at 10:00 a.m. The record indicated Resident #30 had diagnoses that included, but were not limited to, insulin dependent diabetes, post surgical left below the knee amputation (BKA), cellulitis of the left below the knee area, diabetic neuropathy, osteomyelitis, and depression. During an interview with the Director of Health Services (DHS) and Clinical Wound Care Nurse (CWCN) on 4/11/12 at 2:10 p.m., they indicated that on 3/17/12, an order was received to place a wound vac on Resident #30 left stump	F0309	**1. Resident #30 has been discharged from the facility. 2. Other residents with wounds were reassessed by DHS/ADHS or unit manager and skin assessment sheets updated appropriately. 3. Nurses were in-serviced by DHS/ADHS on thorough and consistent assessment and documentation of wounds to include weekly documentation of skin on assessment sheets by DHS/ADHS or unit manager. 4. 3 wounds will be audited weekly by DHS/ADHS or unit manager for thorough and consistent assessment and documentation on skin assessment sheets during CQI for 4 weeks; then 1 wound will be audited weekly for 8 weeks. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.**	05/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	area post surgical BKA (below knee amputation). A physician's order, dated 3/17/12, indicated to apply a wound vac to Resident #30's left stump due to the non healing of the wound with prescribed wet to dry dressings. A physician's telephone order, dated 3/20/12, indicated an order to change the wound dressing for the wound vac every 3 days. On 4/11/12, at 3:10 p.m., LPN#1 and the DHS were interviewed after a request was made for skin assessment sheets related to the area where the wound vac was placed. Both LPN #1 and the DHS stated that they had looked for it, but the assessment sheets could not be found. On 4/12/12 at 8:40 a.m., the DHS was again interviewed regarding the skin assessment sheets, and she again stated that they had not been located yet. An emergency room "Visit Summary Report," dated 3/10/12 at 9:17 p.m., indicated the resident fell onto her left stump in the shower earlier that evening. Resident #30 was transported to ER where physician's records indicated the resident displaced 5 staples from the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	surgical wound site. An order for wet to dry dressings to the area were ordered, and Resident #30 was returned to facility. Review of the resident's clinical record indicated there was no documentation noted in the chart the wound was assessed upon return from the emergency room. No nurses notes from 3/7/12 to 3/12/12, were noted in the chart. From 3/13/12 to 3/17/12, there was notation regarding assessment of BKA stump. Review of nurses notes from 3/20/12, through 4/10/12, failed to indicate any documentation of any measurements or assessments of the wound on the left BKA, or the wound vac. On 4/11/12, at 3:10 p.m., LPN# 1 and DHS were interviewed after request was made for the missing skin assessment sheets, and both LPN #1 and DHS stated they had looked for it, but they had not located it yet. On 4/12/12 at 8:40 a.m., the DHS was again interviewed regarding the missing skin assessment sheets, and she again stated that they had not been located yet. A "Facilities [sic] Skin Assessment Guidelines" indicated: "...documentation			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of wound using Documentation Key, Update the form weekly or with significant change in wound noting the current treatment, medical interventions provided and comments as needed...." A policy and procedure for wound care, dated as revised on 8/24/11, was provided by the CWCN on 4/11/12 at 2:30 p.m., and indicated: "...Wound should be evaluated weekly for effectiveness of treatment...." A policy and procedure for "Facilities [sic] Interdisciplinary Team Careplan," dated 01/06, was provided by the CWCN on 4/12/12 at 2:20 p.m., and indicated, but was not limited to, "...update the Initial Admission Careplan, based on further assessments as needed...." 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to store and distribute food under sanitary conditions in that mighty shakes, nectar thickened drinks and lemon flavored thickened waters were out dated in the refrigerators in the medication rooms. This was during 3 of 3 medication room observations. Findings include: During observation on 4/12/12 at 10:20 a.m., of the 100 Hall medication room with LPN #3, 8 cartons of Mighty Shakes with no expiration dates and no dates to be used last were found. Also found during observation 4/12/12 at 10:20 a.m., with LPN #3, were three honey thickened cranberry and three honey thickened apple drinks with an expiration date of 3/2/12. There were two lemon flavored thickened waters with expiration dates of 2/15/12 and 3/16/12. There were also two Arginaid Extra (supplement to promote wound healing)	F0371	**1. All Mighty Shakes, nectar thickened drinks and lemon flavored thickened waters and supplements that were outdated were removed from refrigerators.** **2. All mighty shakes will receive a pulled date when removed from the freezer.** **3. Kitchen staff were in-serviced on placing dates on mighty shakes when removed from the freezer and on monitoring expiration dates by the Director of Food Service** **4. Nursing staff were in-serviced by DHS/ADHS on checking pull dates and expiration dates on mighty shakes, thickened liquids and all foods prior to using and discarding any that are past expiration or pull date.**	05/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with an expiration date of 1/12/12. During observation on 4/12/12 at 10:10 a.m., of the 200 Hall medication room with LPN #2, there were found to be six plastic cups of nectar thickened orange juice with an expiration date of 11/27/11 and 24 plastic cups of nectar thickened apple juice with an expiration date of 3/15/12. In interview on 4/12/12 at 11:15 a.m., with the Dietary Manager and Chef they indicated the shakes come frozen and when the box is placed in the refrigerator the "pulled date" is placed on the box. The employees come and get them as needed. The package indicated "use within 14 days of being pulled". There was no date on each of the small cartons. In interview on 4/12/12 at 10:10 a.m. with the DHS (Director of Health Services) she indicated the nectar thickened drinks "are expired." "They will be thrown away immediately. No residents have been on these drinks for a while." She could not find a date for when the last thickened drink was used. "We do have residents on the Mighty Shakes, but I have no idea how many or when the last shakes were used." 3.1-21(i)(3)		**5. All thickened liquids, supplements and mighty shakes will be audited by DHS/ADHS or unit manager for expiration and/or pull dates 2 times per week for 4 weeks, then monthly for 4 months. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on record review, interview and observation, the facility failed to ensure that all drugs and biologicals used in the facility had labeling and correct	F0431	**1. All expired and open medications with no open date have been removed from medications carts and destroyed. Audit was**	05/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING _____ B. WING 00	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	expiration dates in accordance with the currently accepted professional principles in 3 of 3 medication carts observed. Findings include: During observation on 4/12/12, at 10:20 a.m., of the 100 Hall medication cart with LPN # 3, there was found to be 2 bottles of Miralax and 1 bottle of Milk of Magnesia with no opened date marked on them. During observation on 4/12/12, at 10:40 a.m., of the 300 Hall medication cart with LPN #1, there was found to be no opened dates on one ProAir inhaler, one Symbacort inhaler, three bottles of Miralax, and one bottle of Milk of Magnesia. There was a vial of Humalog Insulin dated 2/24/12 and 1 bottle of Flonase dated 2/26/12. During observation on 4/12/12, at 11:30 a.m., of the 200 Hall medication cart with QMA #1[Qualified Medical Assistant], there were found to be opened medications that were not marked with opened dates. These included: one bottle of Potassium Cl 10%, one bottle of Acetaminophen Liquid, one bottle of Quaifenesin 100 mg/5 ml (100 milligrams per 5 milliliters), one bottle of Multi-Delyn Liquid, one bottle of		**completed of all medication carts and all expired medications have been removed. 2. All medications have received an open date upon day of opening. All expired medications have been destroyed upon date of expiration. 3. Nurses were in-serviced by DHS/ADHS on applying dates to all medications when opening and on monitoring expiration dates on all medications 4. All medications in the med carts shall be audited by DHS/ADHS or unit manager weekly 2 times per weeks for 4 weeks, then monthly for 4 months. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Phenytoin 125 mg/5 ml, one bottle of Siltusin DM Cough Syrup, four bottles of Milk of Magnesia, 2 bottles of ProMod, one bottle of Pepto Bismol, four bottles of Miralax, one bottle of Mary's Magic Mouthwash, and one bottle of Calcium Carbonate 1250 mg/5 ml. During observation on 4/12/12, at 11:30 a.m., with QMA #1 there were 22 single dose packets of Acetaminophen 325 mg tablets with an expiration date of 3/15/12. In interview with LPN #1 on 4/12/12, at 10:45 a.m., she indicated medications expire 30 days after opening them. In review of the facility policy and procedure received on 4/12/12, at 2:20 p.m., by CWCN, "Storage of Medications" (with no revised date) under "Policy Interpretation and Implementation...3. No discontinued, outdated, or deteriorated drugs or biologicals are available for use in this facility. All such drugs are destroyed." When the policy was provided for review, the CWCN indicated this was the only policy they had on medication dates. 3.1-25(j)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. A. Based on record review and interview,	F0441	**1. Residents #25, 45, and 27 have been monitored for**	05/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the facility failed to maintain their infection control program in that 1 resident received the admission PPD/TB (tuberculosis) test 1 week late (Resident #25) and 1 resident received the admission PPD/TB test 3 weeks late (Resident #43). This affected 2 of 10 residents reviewed for tuberculin testing in a sample of 11. B. Based on record review, interview and observation, the facility failed to ensure that gloves were properly used during PICC Line [a special IV used to give antibiotics] medication administration, in that LPN #2 used the same gloves to change a feeding tube bottle and then do IVPB antibiotic administration. This affected 1 of 1 resident (#45) in the supplemental sample of 1 during 1 of 1 PICC line observation. C. Based on record review, observation and interview, the facility failed to ensure there were standards in place to prevent the development and transmission of disease and infection; in that after a nebulizer breathing treatment the nebulizer canister and tubing were placed in a plastic bag without being properly cleaned. This affected 1 of 1 resident (#27) during 1 of 6 medication pass observations.		**signs and symptoms of infection. No signs or symptoms have been noted. MD was notified of PPD given late and no new orders were given.** **2. Audit has been completed by DHS/ADHS or unit manager of all resident's PPD administration. Any PPD administration found out of compliance were given at the time, MD and families notified. All affected residents were monitored for signs and symptoms of infection.** **3. Nurses have been in-serviced by DHS/ADHS on proper PPD administration, and infection control policy with an emphasis on proper glove use, and cleaning of nebulizer.** **Nurse #2 has been in-serviced by DHS on proper glove use, changing in between tasks and infection control practices.** **Nurse # 1 has been**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: A. 1. Resident #25's record was reviewed on 4/10/12 at 2:30 p.m. The record indicated Resident #25 was admitted on 4/5/12 with diagnoses that included, but were not limited to, Parkinson's disease, high blood pressure, dementia with behaviors, and bleeding into the brain. No documentation was in the record that indicated a first step PPD/TB test had been administered. On 4/12/12 at 3:55 p.m., the Assistant Director of Health Services indicated this resident's first step tuberculin test had not been given and they had called the hospital he had been admitted from and they hadn't given the test either. She said they were going to give him a PPD/TB test now. This PPD/TB test was given 7 days after admission. A. 2. Resident #43's record was reviewed on 4/9/12 at 1:15 p.m. The record indicated Resident #43 was admitted on 2/16/12 with diagnoses that included, but were not limited to, high blood pressure, end stage renal disease, diabetes, slow heart rate, and depression. An "Immunization Record" indicated the		**in-serviced by DHS on proper cleaning of nebulizer and infection control practices.** **4. Audits shall be conducted by DHS/ADHS or unit manager daily in CQI for PPD administration for admissions times 4 weeks, then 1 time per week for 4 weeks, then monthly for 4 months. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	first step PPD/TB test was given on 3/7/12, 3 weeks after admission. During an interview on 4/11/12 at 3:40 p.m., the Director of Health Services indicated that was a PPD/TB test that was missed and they had done an audit and found it. A document titled "Guidelines for TB results Summary Documentation: Residents" indicated: "Purpose: To create a TB Results Summary for each resident member upon admission. Procedures: 1. Upon admission or completed three months prior to admission each resident shall receive a Mantoux PPD test to ensure they are free of tuberculosis. 2. The results of the baseline PPD test, the Mantoux test shall be recorded in the TB Results Summary and placed in the medical record...." B. During observation on 4/12/12, at 8:55 a.m., of the antibiotic administration through a PICC Line for Resident #45, LPN #2 used the same gloves for each of these tasks without interruption: hung a bottle of Jevity 1.5 [liquid nutrition given through a gastrostomy tube], retrieved the PICC Line out from under the dressing, moved the trash can, drew up the antibiotic and mixed it, put the antibiotic			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in the bag of N/S [normal saline], connected the tubing to the bag, cleaned the PICC Line end with alcohol, flushed the PICC Line with 10 cc N/S, and hooked up the antibiotic tubing line to the PICC Line. In interview on 4/12/12, at 9:15 a.m., with LPN #2, she indicated she should change gloves between the two procedures. Review of the policy "Using Gloves" with a revised date of March 2004, received on 4/12/12, at 2:20 p.m., from the CWCN indicated "...Purpose: The purpose of this procedure is to provide guidelines for the use of gloves. Objectives: 1. To prevent the spread of infection and disease to residents and employees...When to use Gloves: 1. When touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin;...4. When cleaning potentially contaminated items; and 5. Whenever in doubt." C. During observation of a nebulizer treatment for Resident #27 on 4/11/12, at 12:45 p.m., LPN #1 finished the treatment and put the nebulizer canister and tubing in a plastic bag without cleaning the canister. In interview with LPN #1 on 4/11/12, at 1:05 p.m., she indicated there is no			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cleaning required. "The canister and tubing are changed every week." Review of the facility policy entitled, "Respiratory/Inhalation Treatments Guidelines" on 4/11/12 at 2:45 p.m., when received from the CWCN indicated "...Procedure:...14. Clean equipment and leave to air dry..." 3.1-18(b) 3.1-18(e)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	The following state residential finding is cited in accordance with 410 IAC 16.2-5.	R0000	The submission of this Plan of Correction does not indicate an admission by RidgeWood Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of RidgeWood Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0356	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to ensure the resident emergency files were accurate and complete, in that 23 of 29 resident files in a census of 29 did not include a picture of the resident. (Residents # 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72) Findings include: Review of the emergency files provided by the DHS (Director of Health Services) on 4/11/12 at 10:30 a.m., indicated no picture was included in 23 of 29 resident	R0356	**1. Residents # 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60,61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72's emergency binders were updated to include their picture by the Executive Director. 2. Each resident's Emergency Information file was reviewed to assure all residents have current pictures. 3. Nurses were in-serviced by DHS/ADHS on keeping the Emergency Information file updated per policy which includes pictures. 4. Emergency Information file will be audited monthly by DHS/ADHS or unit manager for 4 months. Results of these audits will be evaluated by the**	05/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	files. There were no pictures available for Residents # 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68 , 69, 70, 71, 72. Interview with the DHS on 4/11/12 at 11:30 a.m., indicated there were no pictures in 23 of 29 resident emergency files.		**QA committee and audits will continue until 100% compliance is reached for 3 consecutive months. .**	